Tennessee Department of Children's Services

Health History

NAME_____AGE_____D.O.B._____RACE_____

SEX_____COUNTY_____PHONE NUMBER_____
Area Code

PARENT'S NAME _____

PARENT'S ADDRESS _____

DATE OF ADMISSION _____PRIOR ADMISSIONS _____

DATE OF PHYSICAL EXAM_____HEALTH HISTORY_____

INITIAL DENTAL EXAM_____HT. _____WT. _____

ALLERGIES: _____
_____
_____

SCREENING RESULTS:

☐ VDRL _____
☐ ppd (Left Arm)
EYE EXAM Right 20/_____ Left 20/_____

☐ GC/Chlamydia culture
☐ U/A Culture
☐ Cholesterol _____

BLOOD PRESSURE_____PULSE _____RESP._____ TEMPERATURE_____

PRESENT ILLNESSES OR HEALTH CONCERNS _____
_____
_____

PRESENT OR RECENT MEDICATIONS _____
_____
_____

OBTAINED FROM _____
_____

SERIOUS ILLNESSES _____
_____
_____

HOSPITALIZATIONS_____
_____
_____

HAVE YOU EVER HAD MENTAL HEALTH TREATMENT? IF SO, WHERE? _____
_____
_____

SOCIAL HISTORY

DRUG USE AND FREQUENCY:

☐ Marijuana_____
☐ Amphetamines_____
☐ Barbiturates_____
☐ Alcohol_____
☐ Hallucinogens_____
☐ Sedatives_____
☐ Other_____
☐ Tobacco_____

ARE YOU LIVING AT HOME	YES	☐	NO	☐
WITH BOTH PARENTS	YES	☐	NO	☐
SIBLINGS AT HOME	YES	☐	NO	☐
ANY CHILDREN	YES	☐	NO	☐
YOU OR YOUR PARTNER USE CONTRACEPTIVES	YES	☐	NO	☐
WERE YOU IN SCHOOL THIS SCHOOL YEAR? IF NOT, WHY NOT?_____	YES	☐	NO	☐

FAMILY HISTORY (*Indicate who)*

☐ Cardiovascular Disease, Heart Attacks_____
☐ Asthma_____
☐ Diabetes_____
☐ Alcohol Abuse_____
☐ Sickle Cell, Disease or Trait_____
☐ Migraine Headaches_____
☐ Tuberculosis_____
☐ Physical Abuse_____
☐ Cancer_____
☐ High Blood Pressure_____
☐ Seizures_____

REVIEW OF SYSTEMS

1. HEAD AND NECK

NO	YES		COMMENTS
☐	☐	a. Frequent headaches	
☐	☐	b. Sinus problems	
☐	☐	c. Lumps or swellings	
☐	☐	d. Excessive hair loss	

2. EYES

NO	YES		COMMENTS
☐	☐	a. Ever had glasses	
☐	☐	b. Double vision	
☐	☐	c. Blurriness	

3. ENT

NO	YES		COMMENTS
☐	☐	a. Past ear infections	
☐	☐	b. Difficulty hearing	
☐	☐	c. Ringing in ears	
☐	☐	d. Nose bleeds	
☐	☐	e. Frequent sore throat	

4. RESPIRATORY

No	Yes		COMMENTS
☐	☐	a. Asthma	
☐	☐	b. Breathing problems	
☐	☐	c. Tuberculosis	

5. CARDIOVASCULAR

NO	YES		COMMENTS
☐	☐	a. Heart Murmur	
☐	☐	b. Rheumatic fever or heart trouble	
☐	☐	c. High blood pressure	

6. GENITOURINARY

NO	YES		COMMENTS
☐	☐	a. Stomach burning	
☐	☐	b. Ever had ulcers	
☐	☐	c. Hemorrhoids	
☐	☐	d. Diarrhea	
☐	☐	e. Constipation	
☐	☐	f. Vomiting	
☐	☐	g. Yellow eyes or skin	

7. GENITOURINARY - MALE

NO	YES		COMMENTS
☐	☐	a. Burning or pain on urination	
☐	☐	b. Wet the bed	
☐	☐	c. Discharge	
☐	☐	d. Kidney trouble	
☐	☐	e. Sores	

8. VENEREAL DISEASE

NO	YES		COMMENTS
☐	☐	a. Past history of Syphilis, Gonorrhea, or other sexually transmitted disease	
☐	☐	b. If so, when and where exposed	

9. MUSCULOSKELETAL

NO	YES		COMMENTS
☐	☐	a. Joint pain or swelling	
☐	☐	b. Past fractures	
☐	☐	c. Weakness in any limbs	

10. SKIN

NO	YES		COMMENTS
☐	☐	a. Rashes	
☐	☐	b. Sores	
☐	☐	c. Itching	
☐	☐	d. Scars	

Date: _____ History Obtained By: _____

Name of Facility:_____

Female Health History

Name:_____

FOR FEMALES ONLY			FOR CLINIC USE ONLY
No	Yes		Other
☐	☐	a. Age began menses _____	_____
☐	☐	b. Are your menstrual periods regular?	_____
☐	☐	c. How long do they last? _____	_____
☐	☐	d. Date of last period _____	_____
☐	☐	e. Do you have severe cramping?	_____
☐	☐	f. What type of birth control do you	_____
		use?_____	_____
☐	☐	g. How many time have you been pregnant? _____	_____
☐	☐	Full term _____	_____
☐	☐	Premature _____	_____
		Miscarriage _____	_____
		Abortion _____	_____
☐	☐	h. Have you ever had an abnormal Pap smear?	_____
☐	☐	i. Do you have any discharge or itching?	_____
☐	☐	j. Do you have any burning on urination?	_____
☐	☐	k. Any history of bladder or kidney infection?	_____

EPSD&T PHYSICAL EXAMINATION

NAME: _____ DOB: _____ AGE: _____
SEX: _____ ALLERGIC TO: _____

HISTORY/CURRENT PROBLEMS: _____
_____
_____

PAST HISTORY: _____
_____
_____

UNCLOTHED PHYSICAL EXAM: *(X=NORMAL)*

HEIGHT:	WEIGHT:	B/P:	TEMP.:	VISION SCREEN (TEST USED): RT. LT.

- ☐ GEN. APPEARANCE
- ☐ SKIN
- ☐ HEAD
- ☐ HEART
- ☐ EYES/FUND /PUPILS/50M
- ☐ EXTREMITIES
- DOMINANT HAND: ☐ RIGHT ☐ LEFT
- DOMINANT EYE: ☐ RIGHT ☐ LEFT
- ☐ ENT
- ☐ TEETH
- ☐ LYMPH GLANDS
- ☐ LUNGS
- ☐ ABD
- ☐ GAIT
- ☐ GENITALIA (TANNER STAGE _____)
- ☐ BREAST (MALE AND FEMALE)
- ☐ PELVIC EXAM PERFORMED AND NORMAL
- ☐ ANAL/RECTAL (☐ DIGITAL EXAM NOT INDICATED)
- ☐ SPINE
- ☐ NEURO
- DOMINANT FOOT: ☐ RIGHT ☐ LEFT
- ☐ SPEECH AND LANGUAGE

ABNORMAL FINDINGS: _____
_____
_____
_____

DEVELOPMENT: *(X=NORMAL)*

10-12 YEARS	12-15 YEARS	16 YEARS AND UP
☐ PREFERS FRIENDS SAME GENDER	☐ HAS HERO/HEROINE	☐ AT OR ABOVE 10TH GRADE
☐ GOES ALONE TO PLACES IN NEIGHBORHOOD (WITH PERMISSION)	☐ PREFERS PARTY WITH BOYS AND GIRLS	☐ HAS HAD RELATIONSHIP WITH OPPOSITE SEX FOR ONE MONTH OR LONGER
☐ BUDGETS OWN TIME WITHIN BROAD FRAMEWORK	☐ AT GRADE LEVEL IN SCHOOL	☐ HAS PLANS FOR AFTER HIGH SCHOOL
☐ WRITES, ADDRESSES AND MAILS LETTERS	☐ HAS THOUGHT ABOUT FUTURE OR CAREER	☐ LOOKS AFTER OWN HEALTH

HEALTH EDUCATION: *(X=DISCUSSED)*

SAFETY		PERSONAL HEALTH
☐ STREET	☐ FIRE	☐ ALCOHOL/DRUGS/TOBACCO
☐ AUTO	☐ BICYCLE	☐ SEXUAL ACTIVITY/ORIENTATION
☐ SEXUAL ASSAULT/KIDNAPPING	☐ WEAPONS	☐ NUTRITION
		☐ OTHER

IMPRESSION:
_____
_____
_____

PLAN CHECK APPROPRIATE BLOCKS:

- ☐ TB Skin Test (Type_____)
- ☐ Hematocrit
- ☐ Required immunization information read
- ☐ MMR
- ☐ Referred for: _____
- ☐ Urine Analysis
- ☐ Cholesterol
- ☐ Tetanus-Diptheria
- ☐ Other

_____
Signature of Medical Practitioner